Do Hawaii Residents Support Physician-Assisted Death? A Comparison of Five Ethnic Groups

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Abstract

Surveyed were 250 adults in five ethnic groups—Caucasian, Chinese, Filipino, Hawaiian, and Japanese—on questions about physician-assisted death. When asked if there were any conditions under which physician-assisted death should be allowed, 52% said yes, 19% said perhaps, and 29% said no. Differences in response were seen, however, by ethnicity (with less support among Filipinos and Hawaiians), by religious affiliation (with less support among Catholics), and by educational attainment (with greater support among college graduates). Given the controversial nature of this topic, more public education and debate are needed. Meanwhile, physicians are urged to expand discussions with patients on their expectations about and options for end-of-life care.

Introduction

Several demographic and social trends are converging that make the issues surrounding death and dying very controversial. First, the population is aging, with life expectancy in Hawaii among the highest in the world: 76 for men and 82 for women.[1] Second, medical technology has advanced to the point of allowing us to greatly prolong life artificially, often at great cost and loss of life quality.[2] Third, the cost of health care continues to rise and various forms of health care rationing are being proposed.[3] Finally, we see increased attention to human rights and self-determination, even in dying. Taken together, these issues are forcing us to become more aware of the various options available for end-of-life decision making and advanced planning. While many citizens are advocating for more protection of their "right to die," perhaps an equal number of citizens are concerned about the establishment of policy to protect people from being coerced into refusing treatment or committing suicide.[2-4]

Over the past few decades, a number of surveys on attitudes toward euthanasia have been conducted. For example, in a 1977 study, 65% of white respondents indicated support for legalizing physician-assisted death; this percentage rose to 71% in 1989.[5] Since then, several states have taken the issue to their polling places and courts. The 1992 California Death with Dignity Act, a voter initiative to legalize physician-assisted death in that state, was defeated by voters by a 54% majority. However in 1994 and again in 1997, Oregon voters approved measures that would allow physicians to assist competent, terminally ill patients commit suicide. Meanwhile, court-upheld prohibitions on assisted death in Washington State and New York were sent to the Supreme Court, challenging the constitutionality of these prohibitions. The U.S. Supreme Court reviewed these cases together and, in June 1997, unanimously held that terminally ill people do not have a constitutional right to physician-assisted suicide. Specifically, the Court found that the New York and Washington state laws (that make it a crime for doctors to give life-ending drugs to mentally competent but terminally ill patients who no longer want to live) did not violate either the "due process clause" or the "equal protection rights" guaranteed under the 14th Amendment to the U.S. Constitution. The rulings in these cases, however, left room for continued debate and future policy initiatives at the state level.[6]

To help states that may want to develop guidelines for physician-assisted death, a nine-member panel of scholars from law, medicine, philosophy, and economics proposed a model statute for the regulation of legalized physician-assisted death.[7] The model act suggests that physician-assisted death be allowed for individuals who are at least 18 years of age, who have "a terminal illness or an intractable and unbearable illness" (as verified by the primary and a consulting physician), and who are mentally competent to make decisions. Assurances are required that the patient fully understands his/her prognosis and treatment (including palliative care options), that he/she has the opportunity to consult a social worker about available services, and that he/she be advised to inform his/her family. There must be documentation from a psychiatrist or psychiatric social worker that the request is not a result of "undue influence" or "a distortion of the patient's judgment due to clinical depression or any other mental illness." The request must be witnessed by at least two adults (one of which is unrelated and has nothing to gain by the death), "repeated without self-contradiction on two separate occasions at least 14 days apart," and recorded on paper, audiotape, or videotape.[7, 26-29]

Despite what appears to be growing support of the legalization of physician-assisted death, it is important to note that this concept does not carry the same appeal in all ethnic groups. For example, a number of authors have found that the level of support among African Americans is much lower than among white Americans, by as much as 20%.[5, 8-10] Given Hawaii's multi-cultural population, is it

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safe to assume that different cultures have different outlooks on this issue? In previous research by the author, focus groups and key informant interviews were conducted to begin exploring differences among Hawaii's ethnic groups on death practices and end-of-life issues.[11-12] Differences were seen among, and within, ethnic groups based on the respondent's religious beliefs, level of education, experience with artificial life prolongation in family members, and number of generations his/her family had been in the U.S. Focus group questions asked about euthanasia, but not physician-assisted death per se.

To assist Hawaii with its own debate of this issue, Governor Benjamin Cayetano established a Blue Ribbon Panel on Living and Dying with Dignity in February 1997. Its charge was to discuss issues related to death and dying, including physician-assisted death, and make recommendations for policy development. To inform the Governor's committee and future debate in Hawaii, this study built on the earlier, qualitative work to collect opinions from Hawaii residents about physician-assisted death and potential safeguards if this end-of-life option becomes legal.

Method

The study design called for surveys to be administered to 50 adults (25 older adults and, for each, an adult child) in each of five ethnic groups—Caucasian, Chinese, Filipino, Hawaiian, and Japanese—for a total sample of 250. Student interviewers were of the same ethnic background as the group they were assigned to interview except for the student assigned to interview the Hawaiian group; he was a young Caucasian born and raised on the Windward side. Interviewers first identified older adult participants through senior centers and religious organizations in neighborhoods with high proportions of the ethnic group, e.g., Japanese seniors were recruited through centers and temples in the Moiliili area, Filipinos from Waipahu, Hawaiians from Waimanalo and Papakolea, etc. Participating seniors were then asked to identify an adult child willing to participate.

Ease of recruiting varied by group. Caucasian and Japanese participants were easily identified, although Caucasians preferred being interviewed in person while Japanese preferred to be interviewed by phone. The Filipino student interviewer lived in Waipahu and had no problem working through her family and neighborhood connections to recruit participants. Hawaiian and Chinese participants were harder to recruit; the two students interviewing these groups estimated that they asked four adults for each one who agreed. The Chinese group interviewer reported that the high refusal among Chinese was due to discomfort with the topic. The student interviewing Hawaiians reported high levels of distrust, which took time to overcome. In nine cases, a direct parent-child pair could not be interviewed, sometimes because the adult child did not have time to participate or lived out-of-state and did not respond to a mailed survey. In these cases, an effort was made to interview a niece, nephew, or adult grandchild of the older adult. Data collection was completed within 5 months and useable surveys were obtained from 125 seniors and 120 adult children.

The full survey instrument included 85 questions in four parts. Part 1 consisted of questions about age, gender, birthplace, educational attainment, marital status, living arrangements, number of children, religious affiliation, self-rated health, and experience with life-threatening illness among family and close friends. In Part 2 participants were asked if they had any advance directives, such as a living will, and their reasons for completing them or not. Part 3 asked respondents how strongly they agreed or disagreed (5-point Likert scale) with statements about advance planning and decision making, e.g., it's bad luck to plan for death, a person should prepare by writing a living will, a person can trust family to make the right decisions, etc. The final section, Part 4, focused on physician-assisted death, starting by giving a definition. Then respondents were asked: Is there any condition under which physician-assisted death should be allowed? Possible responses were yes, perhaps, and no. If the participant answered no, questioning was concluded. If the participant answered yes or perhaps, another 18 questions were asked about possible conditions, e.g., should the requester be over 18? be mentally competent? have a terminal illness? be in pain? have a diagnosis for which physical or mental deterioration is expected? need a second opinion? need witnesses to the request? etc. Another 11 questions asked about conditions in which a request for physician-assisted death should not be honored, e.g., if the family disagreed, if the physician disagreed, etc. At the conclusion of the interview, the participant was thanked and offered a $10 Longs Drug Store gift certificate. Data management and preliminary analysis were done in Epi-Info, a public-domain data management program produced by the Centers for Disease Control. Reported here are the bivariate analyses of responses related to physician- assisted death.

Findings

Demographics. The demographic characteristics of the sample are provided in Tables 1a (by ethnicity) and 1b (by generation). The differences found among the ethnicities and between generations were not surprising, e.g., the 125 seniors had a higher mean age than the 120 adult children (73 vs. 42 years) and a larger proportion of adult children had college degrees (29% of seniors vs. 65% of adult children). Among ethnicities, the Filipino group was most likely to be married (82% vs. 42-59% of other groups) and least likely to have experienced a life threatening illness themselves or within their families (30% vs. 67-94% of other groups). Only 30% of the Filipino group were college graduates, compared to 38% of Hawaiians, 45% of Japanese, 56% of Caucasians, and 60% of Chinese. As expected 90-98% of the Japanese and Hawaiian respondents were Hawaii-born, compared to 75% of Chinese, 30% of Filipino, and only 23% of Caucasian respondents. In terms of religious affiliation, 88% of Filipinos were Catholic, 59% of Japanese were Buddhists, and the majority of others were Protestant. It is interesting to note that a number of individuals claimed no religious affiliation—4% of Caucasians, 10% of Hawaiians, 14% of Japanese, and 27% of Chinese. While the selection of survey participants was non-random, ethnic distributions for religious affiliation, educational attainment, and birthplace within the sample are in line with state averages. The greater proportion of female than male respondents is also not surprising, as more females than males survive to old age and elders in our sample were more confident that their daughters, rather than their sons, would agree to the second family interview.

Physician-Assisted Death. When asked if there were any conditions under which physician-assisted death should be allowed, 52% of the 245 respondents said yes, 19% said perhaps, and 29% said no. Tables 2a and 2b display the responses to the question by ethnicity

Table 1a.—Demographic characteristics of the sample, by ethnicity (N=215)

	CA n=48	CH n=48	FI n=50	NH n=50	JA n=49	p-val
Mean age (yrs)	61	56	55	57	58	ns
% female	73%	58%	74%	66%	67%	ns
% married	58%	54%	82%	42%	59%	.04
% Hawaii-born	23%	75%	30%	98%	90%	.00
% college grad	56%	60%	30%	38%	45%	.00
% exp lifethreat	67%	74%	30%	94%	80%	.00
Religion						.00
Catholic	27%	13%	88%	26%	0	
Oth Christian	65%	54%	12%	64%	27%	
Buddhist	0	6%	0	0	59%	
None	4%	27%	0	10%	14%	

Table 1b.—Demographic characteristics of the sample, by generation (N=215)

	Seniors n=125	Adult Children n=120	p-value
Mean age (yrs)	73	42	.00
% female	62%	73%	ns
% married	55%	63%	ns
% Hawaii-born	58%	63%	ns
% college grad	29%	65%	.00
% exp lifethreat	65%	65%	ns
Religion			ns
Catholic	31%	31%	
Other Christian	49%	43%	
Buddhist	14%	13%	
None	6%	13%	

and generation, respectively. The responses varied significantly by ethnicity. Specifically, the Filipino and Hawaiian groups were less likely to say "yes" (26% and 46%, respectively) and more likely to say "no" (54% and 44%, respectively) than the other groups. The Japanese respondents were most supportive, with 71% saying "yes" and only 8% saying "no." About 60% of the Caucasian and Chinese groups said "yes" but about 20% of each of these groups also said "no." No significant differences were seen in responses by generation.

For Whom is Physician-Assisted Death Appropriate? As noted earlier, only individuals who answered "yes" or "perhaps" were asked for their opinions about the type of patients who should be permitted to request physician-assisted death and possible safeguards that should be required if physician-assisted death were legal in Hawaii. These included 38 of 48 (79%) of the Caucasians, 39 of 48 (82%) of the Chinese, 23 of 50 (46%) of the Filipinos, 27 of 50 (55%) of the Hawaiians, and 45 of 49 (91%) of the Japanese. By generation, 82 (66%) of the seniors and 90 (77%) of the adult children answered these further questions. To show the responses to the more detailed questions about physician-assisted death, Tables 3, 4, and 5 present two percentages: 1) those who answered "yes" as a percentage of those who were asked the question (first row of numbers) and 2) those who answered "yes" as a percentage of the total sample (second row of numbers).

For example, as shown in Table 3, very few of the respondents, regardless of ethnicity, believed that a person who was depressed should be allowed to pursue physician-assisted death. The Chinese group had a small, but significantly larger, proportion who approved of physician-assisted death for people with depression—21% of those Chinese who responded to the question, representing 17% of the entire Chinese sample. On the other hand, the majority of the Caucasian, Chinese, and Japanese groups felt that a person with a terminal illness accompanied by untreatable pain should be allowed to pursue physician-assisted death. For example, 90% of Chinese

Table 2a.—Are there conditions under which physician-assisted death should be permitted, by ethnicity?

	CA n=48	CH n=48	FI n=50	NH n=50	JA n=49	p-val
Yes	58%	65%	26%	46%	71%	.00
Perhaps	21%	17%	20%	10%	21%	
No	21%	18%	54%	44%	8%	

Table 2b.—Are there conditions under which physician-assisted death should be permitted, by generation?

	Seniors n=125	Adult Children n=120	p-val
Yes	49%	58%	ns
Perhaps	17%	18%	
No	34%	24%	

who answered the question (representing 73% of the entire sample of Chinese) felt that this person should be allowed to get help to die. While 78% of the Hawaiians who answered this question also agreed, that represented only 42% of the full Hawaiian sample (because only 27 of the 50 Hawaiians answered these questions). Small percentages of Filipinos agreed—35% of those who answered the question, representing 16% of the entire Filipino sample. Looking generally at Table 3, it appears that Filipinos and Hawaiians were less likely than the other three groups to agree that physician-assisted death should be allowed. In all groups, however, respondents were most likely to see physician-assisted death as appropriate

Table 3.—A should a person be allowed to get help to die in these conditions, by ethnicity? (% yes)

	CA n=38 n=48	CH n=39 n=48	FI n=23 n=50	NH n=27 n=50	JA n=45 n=49	p-val
Term, pain						
-answerers	76%	90%	35%	78%	84%	.00
-full sample	60%	73%	16%	42%	77%	.00
Term, no pain						
-answerers	24%	33%	22%	19%	35%	ns
-full sample	19%	27%	10%	10%	32%	.02
Not Term, pain						
-answerers	63%	59%	22%	63%	51%	.02
-full sample	50%	48%	10%	34%	47%	.00
Phy dis, now						
-answerers	68%	67%	30%	41%	58%	.01
-full sample	54%	54%	14%	22%	53%	.00
Phy dis, now						
-answerers	42%	62%	26%	11%	44%	.00
-full sample	33%	50%	12%	6%	40%	.00
Ment dis, later						
-answerers	39%	62%	26%	19%	49%	.00
-full sample	31%	50%	12%	10%	45%	.00
Depression						
-answerers	3%	21%	0	0	11%	.02
-full sample	2%	17%	0	0	10%	.05

for individuals in pain and least likely to see it as appropriate for individuals with depression. Responses to these questions were also compared between seniors and adult children, revealing no significant differences (not shown in a table).

Who Should Agree with the Request? Tables 4a and 4b presents the answers to questions about who should agree with the person's request for physician-assisted death. Significant inter-ethnic differences are shown in Table 4a, with the Japanese group most interested, and the Hawaiian group least concerned with, having physicians and spouses agree with the decision. None of the groups were very concerned about having a psychiatrist agree (10-30%) or having their children agree (8-33%). Almost half of the Chinese also said that "no one" should have to agree with the patient's decision, i.e., that the patient's decision should be honored even if no one else agreed with it. Table 4b presents the answers to these questions by generation, revealing a number of significant differences. For example, the seniors were more likely than their adult children to want agreement from their physicians, spouses, and children.

Safeguards. Table 5 presents how the five ethnic groups responded to questions about assuring that a person requesting physician-assisted death understands all the options. In general, individuals who responded to this question believed that the patient should be at least 18 years old and mentally competent and that his/her wishes should be expressed repeatedly, in front of witness, and put in writing. About half of the answerers agreed that the person should be seen by a psychiatrist and about half of the Filipino, Hawaiian, and Japanese respondents felt that the person should be counseled by his/her minister as well. A third of respondents were supportive of having the person try anti-depressants and about half felt the

Table 4a.—Who should agree with the person's request for physician-assisted death, by ethnicity? (% yes)

	CA n=38 n=48	CH n=39 n=48	FI n=23 n=50	NH n=27 n=50	JA n=45 n=49	p-val
Primary MD						
-answerers	63%	44%	43%	33%	77%	.00
-full sample	50%	36%	20%	18%	71%	.00
2nd MD						
-answerers	58%	51%	35%	44%	60%	.04
-full sample	46%	42%	16%	24%	55%	.00
Psychiatrist						
-answerers	24%	21%	22%	22%	33%	ns
-full sample	19%	17%	10%	12%	30%	ns
Spouse						
-answerers	47%	51%	48%	19%	58%	.02
-full sample	37%	41%	22%	10%	53%	.00
Children						
-answerers	32%	38%	39%	15%	36%	.03
-full sample	25%	31%	18%	8%	33%	.05
No one						
-answerers	37%	59%	35%	44%	36%	.00
-full sample	29%	48%	16%	24%	33%	.02

patient should try increasing pain medications before proceeding. (The Filipino group was least supportive of pharmaceutical interventions.) Small percentages in each group supported the idea of a waiting period. A common comment was "after you have the person do all those other things, a waiting period is unnecessary." There were no significant differences by generational group and so these data are not shown in a table.

Discussion

The data suggest that Hawaii's major ethnic groups have different responses to the legalization of physician-assisted death, with greater support seen among Chinese, Japanese, and Caucasian residents and less support seen among Filipino and Hawaiian residents. On first pass, it is interesting to note that the level of acceptance among groups is roughly related to the groups' life expectancies. Specifically, Chinese and Japanese in Hawaii have the longest life expectancy, while Hawaiians have the shortest.[1] On the other hand, the Filipino group, which is the third most longevous of the five groups, had a very low acceptance level, and this is most likely attributable to the high percentage of Filipinos who are Catholic. In fact, a separate analysis of religion and support of physician-assisted death showed that Catholics were more likely to say "no" while Buddhists and Protestants were more likely to say "yes" ($p<.001$). The "yes" group was also likely to have more years of schooling than the "no" group ($p<.001$). Unexpectedly, few differences were seen when the data were analyzed by generation, i.e., seniors vs. adult children. Future multivariate analysis of these data will examine the relative effects of ethnicity, religion, education, and experience with life-threatening illness in self and loved ones on attitudes toward physician-assisted death.

Also of interest are some of the details about who should be allowed to get help to die and what safeguards should be put in place.

Table 4b.—Who should agree with the person's request for physician-assisted death, by generation? (% yes)

	Seniors n=82 n=125	Adult Children n=90 n=120	p-val
Primary MD			
-answerers	70%	42%	.00
-full sample	46%	32%	ns
2nd MD			
-answerers	65%	40%	.00
-full sample	43%	30%	ns
Psychiatrist			
-answerers	27%	23%	ns
-full sample	18%	17%	ns
Spouse			
-answerers	58%	36%	.00
-full sample	38%	27%	ns
Children			
-answerers	44%	22%	.01
-full sample	29%	17%	ns
No one			
-answerers	42%	43%	ns
-full sample	28%	32%	ns

Table 5.—How can we make sure this person understands all the options, by ethnicity? (% yes)

	CA n=38 n=48	CH n=39 n=48	FI n=23 n=50	NH n=27 n=50	JA n=45 n=49	p-val
At least 18 yo						
-answerers	63%	51%	78%	62%	66%	ns
-full sample	50%	41%	36%	33%	61%	.03
Competent						
-answerers	82%	85%	87%	85%	87%	ns
-full sample	65%	69%	40%	46%	80%	.00
Psychiatrist consult						
-answerers	32%	56%	43%	63%	51%	.03
-full sample	25%	46%	20%	34%	47%	.04
Relig consult						
-answerers	34%	38%	52%	52%	58%	ns
-full sample	27%	31%	24%	28%	53%	.03
Inc pain meds						
-answerers	52%	51%	43%	63%	53%	.01
-full sample	41%	41%	20%	34%	49%	.03
Anti-depress						
-answerers	34%	28%	22%	54%	40%	.00
-full sample	27%	23%	10%	29%	36%	.04
Wish written						
-answerers	87%	74%	96%	92%	87%	.05
-full sample	69%	60%	44%	50%	80%	.01
Wish witness						
-answerers	74%	77%	91%	81%	71%	ns
-full sample	59%	63%	42%	44%	65%	.05
Wish repeat						
-answerers	50%	42%	65%	41%	51%	ns
-full sample	40%	34%	30%	22%	47%	.04
Wait period						
-answerers	34%	38%	26%	22%	36%	.00
-full sample	27%	31%	12%	12%	33%	.05

The largest proportions of respondents felt that physician-assisted death was acceptable for an individual with untreatable pain, especially if they also were terminally ill. This opinion is in line with the model statute described above.[7] There was very little support for physician- assisted death for depression, which is in concurrence with the model statute and other pro-euthanasia documents that call for a psychiatric evaluation to rule-out depression in requesters.[3,7] This issue is more controversial in the Netherlands where only 3% of patients who request help to die are referred for psychiatric evaluation and where cases in which individuals have been helped to die because they had "intractable depression" have been reported.[13-14] It is gratifying, then, that almost 50% (range 32 to 63%) of respondents in the Honolulu study felt that a requester should consult with a psychiatrist and 34% (range 22 to 54%) felt that a requester should try anti-depressants before proceeding.

Methodologically, the study had several limitations. First, the sampling was not random. Participants were volunteers, recruited through formal organizations in Hawaii's various communities, and therefore were likely to differ from the general population. For example, that the older adults were participants in senior centers and religious organizations probably meant that they represented a healthy and socially active segment of the older adult population for whom these questions might be somewhat academic. Their children were also likely to be healthy. Participants self-selected to be interviewed, and it is suspected that those adults who were uncomfortable with the subject matter, unsure of their feelings about it, or distrustful of the survey process or the topic were likely to refuse. Also, the sample included no residents of the Jewish faith, in part because the Caucasian interviewer had more than enough volunteers before having a chance to recruit participants through Temple Emanu-El. Finally, interviewers reported that the ordering of questions may have created a bias toward answers that upheld an individual's right to free choice, rather than answers that reflected a greater concern for consumer protection. Thus, the survey results probably overestimate the acceptability of physician-assisted death in the state. A next step would be to estimate support of physician-assisted death in the general population through a random sample phone survey, perhaps through the Hawaii Health Survey or a separately-funded effort.

Despite limitations, the data suggest that different ethnic groups have different feelings about the acceptability of physician-assisted death. From the high turn-down rate, it is also expected that individuals in some groups have not even begun to think about physician-assisted death as an end-of-life option. The recommendation, then, is for more education and discussion about the issue, especially among the Filipino group in which opposition is high and among the Hawaiian and Chinese groups in which our sampling was most biased due to high refusal rates. Given that the Governor's Blue Ribbon Panel allowed itself a year to review the issues, it seems reasonable that the rest of the population will need time for education and discourse as well.

Regardless of how quickly Hawaii and other states move into the debate about physician-assisted death, individual physicians need to increase their efforts to discuss end-of-life options with their patients. Research suggests that outpatients want their doctors to initiate discussions about advance planning, and that these discussions should occur after their physician-patient relationship is established but while the patient is still well.[15] Conversations should address values and expectations related to life and its artificial prolongation; knowledge and thoughts about palliative care options, such as hospice; and completion of living wills, documents that assign proxy, and code-status forms for hospitalized patients. There is empirical evidence to suggest that these discussions alone provide a "long-lasting sense of improved understanding and being cared for" among patients, as well as giving physicians vital information about their patients' treatment preference.[15, 1066]

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